EXPOSURE

Continuum of Care

A response to Poverty, Drug use, HIV and AIDS

MAINline

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ACKNOWLEDGMENTS

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Front Cover

A family in Lahore, Pakistan who have been affected by poverty, drug use, HIV and AIDS and have benefitted from the continuum.

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Introduction

This booklet chronicles the journey undertaken to date by community based organisations, as they have come to understand and respond to the triple nexus of poverty, drug use and HIV in Asia.

The journey was made possible through exposure to the environment of drug use in Asia. Throughout the journey, the trust that was placed in the potential of marginalised individuals and disenfranchised communities was amply vindicated. The approach taken expanded on the principle of harm reduction. Community based organisations framed a response within the vision of the Continuum of Care. The outcome capitalised upon and cross-fertilised vertical interventions.

'Exposure' will be interspersed throughout with stories of those who have benefited from interventions since 2005.

People using drugs and homeless in New Delhi, India

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Context of drug use in Asia

Beginnings

In cities and towns across Asia drug users eke out a chaotic existence in dire poverty, homelessness and unemployment. For many, a square meal every day is a luxury. People who use drugs are a stigmatised and marginalised group, and in many countries they form an underclass. The illegality of their drug use often places them in conflict with the law. Ostracised by local communities, they struggle to obtain gainful employment and often resort to petty crime to survive. As a result of sharing injecting equipment, they are vulnerable to transmission of HIV and Hepatitis C (HCV).

In South Asia, as many as 50% of men using drugs are married with young children. The women (wives) are the main breadwinners in their families, with the major responsibility of managing their household and taking care of their children. Because of the ostracism and stigma of drug use, these families are often marginalised and dysfunctional. The future development and prospects of the children are in jeopardy, and their access to health care, stable education, life skills and employment, bleak.

"I live and work on a vegetable farm near Sargodha with my five children. It is a back-breaking job. The landlord provides us a room where we cook, sleep and live. My children help me with my work on the farm. I cannot afford to take days off, even when I am sick, because I am paid on a daily wage basis. I barely manage to provide two meals and shelter to my children."

Mother of five children, Sargodha, Pakistan.

In Southeast Asia, amphetamines and crystal meth are the major drugs of choice, leading to chaotic and dysfunctional lives. Young people are being drawn into drug use in considerable numbers - many (in South Asia) injecting drugs in their early teens. They represent 1-5% of the population of adolescents in the Asia-Pacific region. Drug use is one of a range of vulnerabilities that affect this population. Often homeless and disenfranchised, these young people live on the street and are exposed to violence, sexual predation, hunger, and a lack of basic facilities. They also lack health care or opportunities for growth or advancement.

The tragic reality is that these young people are ignored. They are rarely consulted, and existing services do not address their needs. HIV prevention services that provide support to adults who use drugs are inappropriate solutions for these young people. Such services are not skilled in child protection, and do not have the additional and necessary child/young person development focus to secure a future. Generic child protection and development services are inexperienced in addressing the needs of young people who use drugs and do not include them in their services. Consequently, these young people "fall between two stools".

No simple solution addresses the chaos observed on the streets. Vertical interventions planned by governments, international donors, and the global fund to prevent the transmission of HIV through drug use do not fully respond to the chronic instability, oppression, and hopelessness faced by people living on the streets.

> "*Why should I care about whether I get HIV or not? I am going to die on the streets here anyway.*"
>
> A street-based drug user in Pakistan.

A response commensurate with reality

Faced with this context, community-based organisations needed to develop a response that matched the reality of people's lives. In the response, community-based organisations needed to remain faithful to what they were observing as they worked on the streets. Based on relationships formed with street-based drug users, they had understood the individual's capacity for change. They had recognised the potential in this disenfranchised population.

Community-based organisations needed a vision and framework that responded comprehensively to the full picture. They needed a coherent approach that would enable them to articulate the reality of people's lives, to draw attention to both the potential and needs of street-based drug users, and to frame a response that attracted the necessary resources.

Chasing crystal meth; the emerging drug of choice in Phnom Penh, Cambodia

Van Nith (name changed), Phnom Penh, Cambodia

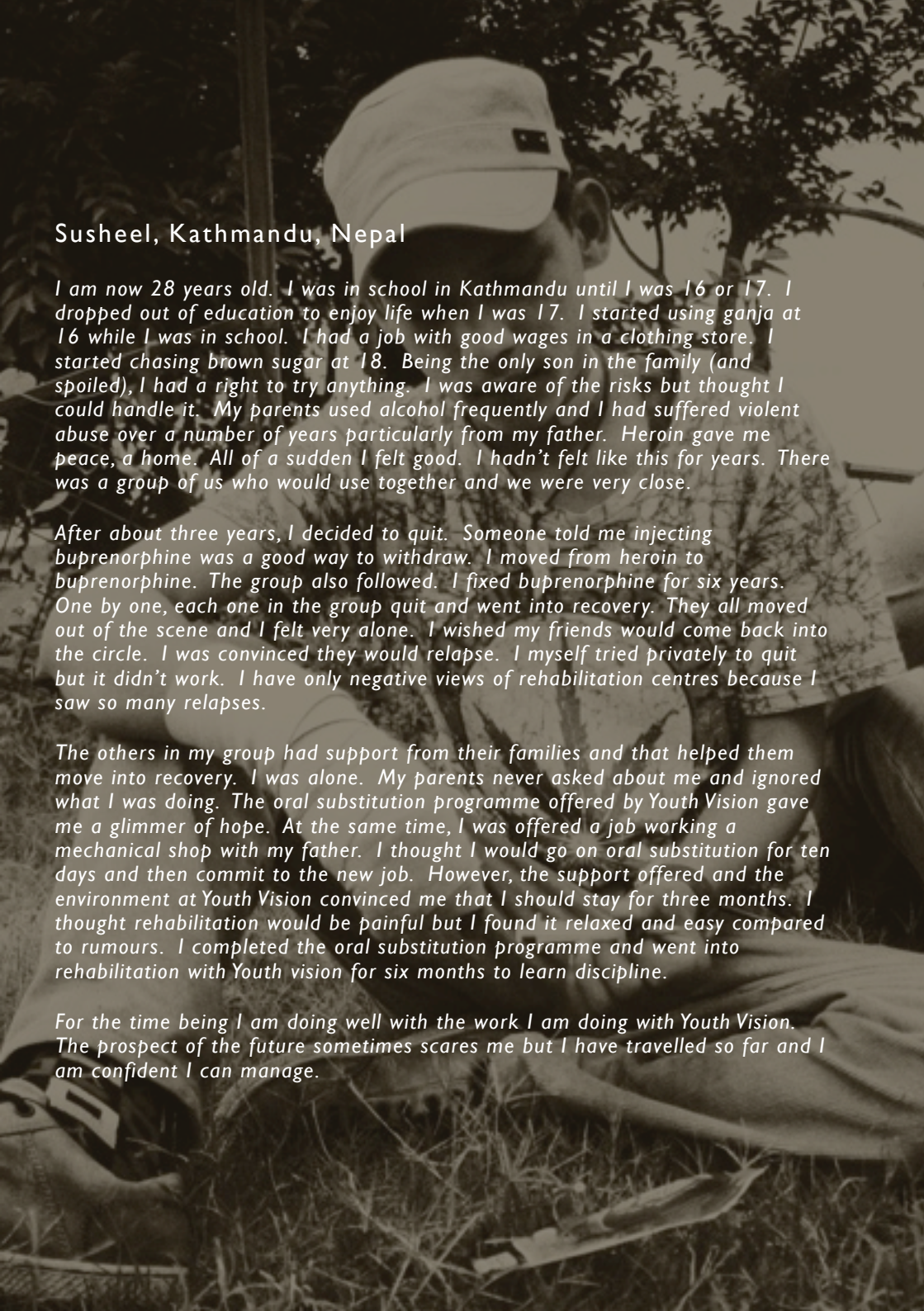
Van Nith is 21 years old and entered the Mith Samlanh rehabilitation programme in November 2007. Their property being stolen, He moved with his family to Phnom Penh when he was one year old. Van Nith's father is a medical doctor but left Van Nith's mother to live with his second wife when Van Nith was four years old. He has since lost contact with his father.

Van Nith attended high school until grade 10 but started using drugs – first amphetamines and then two years ago crystal meth. He lived on the streets of Phnom Penh for two years and witnessed many of his friends join Mith Samlanh's rehabilitation programme. However, Van Nith did not have any appetite to quit drugs. He was afraid of withdrawal symptoms.

Crystal Meth amplified his moods making him feel exhilarated but also sometimes feeling bad and aggressive. He had an increased desire for sex on drugs and often the gang would be involved in group sexual activities.

Because of the persistence and encouragement of the Mith Samlanh outreach team, one day he decided to quit. The opportunity to gain employment training motivated him to enter rehabilitation.

He has a good feeling since entering the Green House – Mith Samlanh's detoxification and rehabilitation centre and received very good personal care and support. He is optimistic about his future.



Susheel, Kathmandu, Nepal

I am now 28 years old. I was in school in Kathmandu until I was 16 or 17. I dropped out of education to enjoy life when I was 17. I started using ganja at 16 while I was in school. I had a job with good wages in a clothing store. I started chasing brown sugar at 18. Being the only son in the family (and spoiled), I had a right to try anything. I was aware of the risks but thought I could handle it. My parents used alcohol frequently and I had suffered violent abuse over a number of years particularly from my father. Heroin gave me peace, a home. All of a sudden I felt good. I hadn't felt like this for years. There was a group of us who would use together and we were very close.

After about three years, I decided to quit. Someone told me injecting buprenorphine was a good way to withdraw. I moved from heroin to buprenorphine. The group also followed. I fixed buprenorphine for six years. One by one, each one in the group quit and went into recovery. They all moved out of the scene and I felt very alone. I wished my friends would come back into the circle. I was convinced they would relapse. I myself tried privately to quit but it didn't work. I have only negative views of rehabilitation centres because I saw so many relapses.

The others in my group had support from their families and that helped them move into recovery. I was alone. My parents never asked about me and ignored what I was doing. The oral substitution programme offered by Youth Vision gave me a glimmer of hope. At the same time, I was offered a job working a mechanical shop with my father. I thought I would go on oral substitution for ten days and then commit to the new job. However, the support offered and the environment at Youth Vision convinced me that I should stay for three months. I thought rehabilitation would be painful but I found it relaxed and easy compared to rumours. I completed the oral substitution programme and went into rehabilitation with Youth vision for six months to learn discipline.

For the time being I am doing well with the work I am doing with Youth Vision. The prospect of the future sometimes scares me but I have travelled so far and I am confident I can manage.

Relationships central to effectiveness

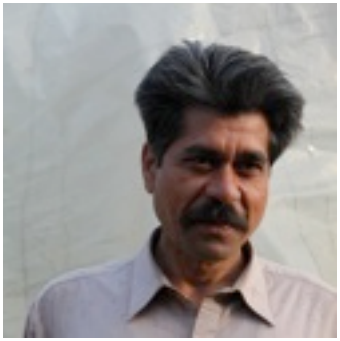
As community-based organisations began to build contact with street-based drug users and provide services, relationships were established. In this context, the full picture of both deprivation and potential for growth became evident. Through trial and error as well as dialogue with other partners in an established Asian network, community-based organisations began to respond to the complex needs that had been identified, and began to support the potential for change and growth.

It quickly became evident that the received methodologies – drug treatment and therapeutic communities - were remote and expensive. Most street-based drug users had little opportunity for change through those means. Those with families could not afford the time or luxury of entering into extended treatment.

Seeking to reduce the harm caused by drugs was a good place to start. At street level, however, they discovered there are no rules, just relationships. Needles and syringes were distributed to prevent sharing and transmission of blood-borne viruses. Basic health care and the dressing and management of infected wounds brought about a deeper contact, which opened up the reality of people's lives and contexts. As consistent support was provided, individuals changed and took responsibility.

As the HIV epidemic raged through the streets of Asia, there were casualties. Those using drugs who were HIV+ often did not have access to HIV diagnostics, treatment and care services. The life stability provided through contact with community-based organisations facilitated access to these vital services. The acceptance and opportunities for growth and change brought about confidence, stability in peoples' lives, and became essential prerequisites in guaranteeing adherence to treatment programmes.

Drop-in centres provided a place to rest and recuperate. Games were provided, showers were made available, clothing was recycled, and referrals were made for health care and legal services. The underlying principle was to remain non-judgemental. Contact became consistent and available, and trust was built up. Through this process, individuals regained their dignity and self-worth.


The repeated request: "Give me a job"

A repeated refrain from many on the streets was that people had had enough. They wanted out. They wanted to escape the misery, and most wanted work. As a result, the old treatment methodologies were taken out, dusted down, and given a new airing. Drug treatment programmes were shortened, and simple detoxification prepared the ground for individuals to enter employment training. That meant that those entering treatment were able to earn their keep very quickly upon completion of detoxification.

A regional programme supported by the European Union introduced the model of businesses that train and support street-based drug users so that they can enter the workforce. Developing these training businesses changed and revitalised the culture of organisations. The options available to people on the street increased.

Over time, the vast potential that was hidden within street-based drug users became apparent. When provided with opportunities for training and employment, most people grasped it with both hands. Their contribution to the growth of the various business ventures became immeasurable, and the faith invested in them was amply rewarded. Throughout this booklet, simple stories are told about the impact of initiatives on these individuals and families. These stories represent a fraction of the lives changed as community-based organisations invested their time and energy in people's futures.

Linking up the various elements of services into a continuous whole provided a pathway for people, one that met their needs, recognised their potential, and was easy to enter into. The vision of community-based organisations grew broader. A paradigm began to emerge that provided a sufficient basis to respond effectively to the desolation of the streets. The continuum of care was born.

The repeated request: "Give me a job"

Skills training and employment, intensive vegetable farming, Islamabad, Pakistan.

Improved health and socio economic status through a pragmatic approach.

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Partnership and Collaboration

It was at this point, in early 2005, that Mainline joined forces with the Asian partners under a project called "From Margins to Mainstream". Mainline's introduction to Asia was facilitated by the Asian Harm Reduction Network. The main tenet of this project was to reach out to street-based drug users on the margins of society – poor, discriminated against, unemployable, vulnerable to many diseases (especially HIV) - and to trust their potential and support their journey back to the mainstream. The continuum of care provided the perfect framework to support this journey, by acknowledging a process of change, and by accepting the reality of peoples' lives and contexts.

From its beginnings, Mainline has been a strong advocate of the principle of harm reduction in regard to drug use. Mainline's long history in supporting this pragmatic, non-judgemental approach, which aims at improving the health and living conditions of people using drugs, dovetailed with their partners' vision of the continuum of care. Importantly, while maintaining the principle of harm reduction, Mainline also recognised, through exposure to drug use contexts in Asia and the debilitating effect of the living conditions of street-based drug users, that the effects of poverty also needed to be addressed. The dialectic involved in combining harm reduction principles within the broader scope of the continuum of care enhanced both.

From the outset, Mainline built a collaborative relationship with its southern partners. Projects were designed in consultation with these partners, and were based on detailed assessment and identification of both capacities and needs. Importantly, Mainline recognised the expertise, the valuable experience, the analyses of contexts from which partners had framed their approach to the work.

Within the emerging partnership, technical support was provided; north-to-south, and in many instances south-to-south, to improve key elements of how services were implemented.

Mainline and partners recognised the importance of good financial controls and administrative systems that would ensure transparent accounting. Local internationally-accredited auditors were engaged to ensure that each organisation developed good fiscal and accounting systems.

Developing interventions based on proven methodologies and scientific analyses was essential. Mainline supported its partners in developing their data-collection systems by using software first introduced by Nai Zindagi, Pakistan. This meant that the impact of services could be readily identified, and adjustments made where necessary.

Technical support was also provided to ensure good strategic and operational management capacity, as well as sound organisational infrastructure and accountability.

Partnerships were fostered through exchange visits between community-based organisations across the region. Introducing new partners and supporting their development was achieved by mentoring that was provided by those who had an already established capacity.

Linking organisations across Asia within a network generated support, dialogue, understanding, encouragement, and commitment. The network became the engine room of the continuum of care.

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The Continuum of Care

The integration of all the services that were being developed to support street-based drug users became known as the "continuum of care". This is at once a vision, a model, and a strategy. The vision of the continuum is that people vulnerable to poverty, drug use, and HIV have access to affordable, accessible, and supportive services that meet their needs, vulnerability and aspirations. The principle behind the continuum is that services should respond to identified needs, and do so in the most effective way possible. The continuum also recognises and acknowledges the potential of each individual. The specific shape of services is arrived at via assessments of the contexts, needs, and capacities. Services are then strategically linked so that they complement and enhance each other.

The reality is that poverty, drug use, and HIV require a wide range of strategic responses in the Asian context. The continuum provides an effective framework by combining the various responses: street-based outreach programmes and drop-in centres, drug treatment, employment training and employment, HIV and AIDS treatment care, and support services.

Each element has integrity

Each of these service elements will be individually described. Each element has integrity and can stand alone. The effectiveness of the continuum is that it connects these elements in a seamless whole. And most importantly, the continuum provides room for growth and evolution, as contexts change and understanding and knowledge grow. In other words, the elements are not prescriptive; they can change and be added to.

Vertical interventions initiated and promulgated by governments and international donors are, by their very nature, limited in scope. They cannot address the full reality and context of people's lives. Indeed, by sometimes framing responses in a one-dimensional way, e.g. as drug demand reduction or HIV prevention strategies, such interventions can unintentionally shut off individuals and families from essential poverty reduction or development measures.

The appeal of the continuum is that it is not just a response based on HIV prevention or treatment. Nor is it just a simple disease-control strategy. It is not just an imperative to reduce the demand for drugs. It does not just aim at alleviating poverty. The continuum incorporates all of these components, and leaves room for more.

The continuum creates opportunities

A full understanding and implementation of the continuum enables community-based organisations to capitalise on a range of opportunities. The obvious sources of funding and support - HIV prevention and drug demand reduction, are amplified by other funding opportunities that support:

- Economic development (if small businesses have been introduced);
- Technical, Vocational and Educational Training (TVET) programmes
- Child development and education (street-children using drugs are children too);
- Inclusion of women socially and economically (wives of men using drugs are extremely marginalised);
- Agricultural development (where people using drugs originate from rural, farming communities), etc.

In other words, the continuum of care provides the vision and strategic imperative that enable community-based organisations to recognise people's potential and capacities. The continuum frees people and communities affected by poverty and drug use of the restrictive bracket of HIV prevention and drug demand reduction programmes. The continuum enables community-based organisations to absorb the expressed and real needs of communities, identify the capacities and potential of individuals, and imaginatively seek resources from many different avenues through which a response is framed.

Elements of the continuum of care

The continuum of care evolved as community-based organisations began to respond to capacity and need - step by step. The service elements were considered building blocks. As each element was constructed, it was considered within the overall vision and integrity of the continuum.

The continuum continues to evolve, as knowledge increases about the environment, context, capacity, and need. Currently, the continuum of care consists of outreach programmes, drop-in centres that provide a range of services and interventions, access to HIV diagnostics, drug treatment, and socio-economic reintegration.

The continuum creates opportunities for families.

Syringe Exchange Programmes an essential component of outreach.

Drop-in centres and street-based outreach

Drop-in centres are usually linked with outreach programmes. Over time, community-based organisations have discovered that concentrating services at various drug-consumption points (called hotspots) is the most efficient way of achieving an impact.

The outreach team is dispersed to various hotspots that are mapped beforehand. A regular timetable is introduced that ensures clients know when services will be available at each hotspot. This means clients do not have to pay bus fare to attend the drop-in centre. In addition, concentrating clients in the (usually) small confines of drop-in centres can lead to the inadvertent spread of opportunistic infections, particularly TB. This can be avoided through delivery of services by outreach teams. When outreach workers identify needs that require more elaborate treatment than the treatment that is available on the street, referrals are made to the drop-in centre.

Developing an effective outreach service is a critical element in the continuum, and this challenges the ethos of many organisations. In traditional residential drug treatment centres, for example, the client is expected to conform to the centre's established rules and ethos. Outreach workers, on the other hand, have no means of imposing such rules on the street, and have to adapt. This involves a cultural shift.

The capacity to build supportive relationships remains key. An effective street worker should be able to gain acceptance without being sucked into the often dysfunctional dynamics of the street. The following list of qualities in the booklet "On the Road Again"*, compiled by the Asian partners and published by DO International, provides a template for a good street worker. An outreach worker should be:

- Able to be non-threatening to those living on the street.
- Willing to work, as and when needed, in a consistent manner - often outside regular hours.
- Able to gain acceptance on the streets without compromising the organisation's ethos or values.
- Able to adapt to the changing dynamics of the street.
- Able to negotiate with the local community to contribute to better understanding and support.
- Able to maintain boundaries, and be responsive to training and guidance.
- Informed and aware of the law regarding the consumption of illegal drugs.

* www.naizindagi.com/Reports/On%20the%20road%20again.pdf

The aim of an outreach programme is to minimise the thresholds that clients have to pass in order to receive services. Low-threshold services are defined as those that reduce, as much as possible, the "hoops" people have to jump through in order to receive the necessary support and treatment. Providing essential services at hotspots dramatically reduces thresholds if these services are delivered in a friendly, hospitable, and non-judgemental manner. Providing services at hotspots also reduces the need for clients to travel and spend their meagre resources on receiving essential support. Hotspots are mapped out during the beginning of an outreach programme to ensure that services are delivered where they can achieve the greatest impact.

A range of services can be provided by outreach teams. Among these are:

Registration: This is pivotal in the relationships established between the individual and the organisation. In effect, registration represents a recognition by the individual that he or she needs help. It also represents a contract with the organisation that this help will be provided in a consistent and professional manner. Basic registration can be completed by outreach teams, although comprehensive registration is best completed by referral to the drop-in centre that is linked with the outreach programme. Registration, when coupled with good analytical software, ensures that the impact of services is continuously measured, and that service design can respond to changes in the environment and context. It also facilitates the recording of services provided to clients.

Needle and syringe distribution: A Needle and Syringe Programme (NSP) has been proven worldwide as the most effective and cost-efficient way of reducing the sharing of injecting equipment among people who use drugs, thus reducing the prevalence of HIV and Hepatitis C (HCV). Appropriately sized needles and syringes (along with paraphernalia such as swabs, filters, etc.) are distributed among clients, which ensures they have sufficient means to avoid the sharing of contaminated equipment. This is usually accompanied by some form of collecting used syringes, an important and responsible activity that gains the support of the wider community.

Wound dressing and abscess management: Many of those who inject drugs, either through ignorance, poor equipment or desperation, end up with injection injuries. As a result of poor hygiene and lack of access to medical or hospital care, these wounds can rapidly become painful and dangerous, potentially leading to gangrene, amputation, or death. Outreach teams trained as paramedics to dress simple wounds provide substantial benefit to clients, and help build rapport and confidence.

Street based wound management by an outreach worker, Rawalpindi, Pakistan

The confidence and trust that are built up through the delivery of these essential services have a marked effect on street-based clients. It is often the first time that anyone has shown concern and compassion for their situation. Receiving support from outreach teams is usually an acknowledgement by the client that he or she needs help and treatment, and represents the first step away from the marginalisation and exclusion brought about by their poverty and drug use.

The excellent document "Guide to Starting and Managing NSP"*, published by WHO, UNAIDS, and UNODC, outlines everything that an organisation needs to know about running a comprehensive street outreach programme, and is available online.

* www.who.int/hiv/idu/Guide_to_Starting_and_Managing_NSP.pdf

Drop-in Centres

The drop-in centre acts as a haven from the difficult life of those surviving on the streets. The ethos of the centre is therefore welcoming and friendly. In a sense, the drop-in centre acts a bridging point, a place of rest, and an opportunity for deliberation. The house rules of the drop-in centre are best developed in close consultation with those using the centre. This ensures that people feel at home, and that they have some ownership and pride in the centre from the beginning.

The drop-in centre is where essential services are provided. As the twin epidemics of HIV and HCV coursed through Asia, the demands on community-based organisations and their drop-in centres have grown. In their technical guide, WHO, UNODC, and UNAIDS have nominated nine key interventions that have the greatest impact on HIV prevention and treatment. This guide is also available online.*

The interventions are:

- Needle and syringe programmes (NSPs)
- Opioid-substitution therapy (OST) and other drug-dependence treatment
- HIV testing and counselling (T&C)
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for IDUs and their sexual partners
- Targeted information, education, and communication (IEC) for IDUs and their sexual partners
- Vaccination, diagnosis, and treatment of viral hepatitis
- Prevention, diagnosis, and treatment of tuberculosis (TB).

In the Asian context, many of these essential interventions are aspirational. Community-based organisations continue to struggle to ensure their existence and continuity. In many countries, governments assume responsibility for the provision of some of these services. For people who use drugs (a population that is illegal, marginalised, and discriminated against) to be expected to approach generic, government-run services for treatment is often unthinkable.

www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf

In this context, community-based organisations and drop-in centres in particular play an important role in supporting and guaranteeing access to these services. The context of a trusting relationship as well as a sense of acceptance and support are critical in ensuring this. The security and life-stability provided by drop-in centres and outreach teams become an essential pre-requisite for adherence to treatment.

Community-based organisations have also understood other essential needs that can be addressed at the drop-in centre, and that make life much more humane for street-based clients. Nutrition is paramount in these additional services. Food insecurity, defined as the limited or uncertain availability of safe and nutritionally adequate food, has become one of the greatest barriers to effective HIV prevention and treatment. Among homeless drug users (who are HIV positive), lack of good nutrition increases their vulnerability to infection. It also has an impact on treatment adherence and therefore clinical outcomes. Strong associations have been found between early mortality and food insecurity among people on ART.

Studies in Delhi revealed that when good nutrition was available as part of the overall service, homeless people were much more receptive to harm-reduction messages, were more stable in treatment, and had positive clinical outcomes. This underlines the tenet that a simple disease-control model is limited in the Asian context of poverty and malnutrition. To be effective, programmes should be designed in context, with nutrition as an essential component.

Byabani Farms

Byabani farms evolved from many successful business ventures pioneered by Nai Zindagi, Pakistan. Over 10 years, Nai Zindagi had developed profitable businesses manufacturing high-quality furniture; fashion leather bags; recycled willy jeeps. In the process, Nai Zindagi understood the business world and had been successful in introducing street-based drug users to employment. The draw back was that these business ventures were limited in providing jobs to just a fraction of those who need that support.

In 2005, Nai Zindagi began their farm ventures. In the first instance, vines were planted on 25 acres of land. Within two years, the business was profitable, generating income from sales of table grapes which secured the initial investment. The people trained and introduced to this work numbered more than 500 in four years.

Viticulture is a unique skill and knowledge and some opportunities for onward employment was available. However, it was not feasible for graduates of viticulture training to set up their own vineyard. Land was costly. Vines produce once annually. This was an unsustainable position for the individual and his family.

As a result of learning involved in producing a successful vineyard, Nai Zindagi diversified into vegetable cultivation using raised bed technology and tunnel structures. Production of profitable vegetables were tracked, skills honed in perfecting quality, markets understood and access gained.

The vegetable farming venture was much more relevant to those undergoing training and graduates had the necessary skills to develop their own small farm or find employment. The challenge experienced in previous business ventures - How to find a route to employment in sufficient numbers? - was addressed by Byabani Farms.

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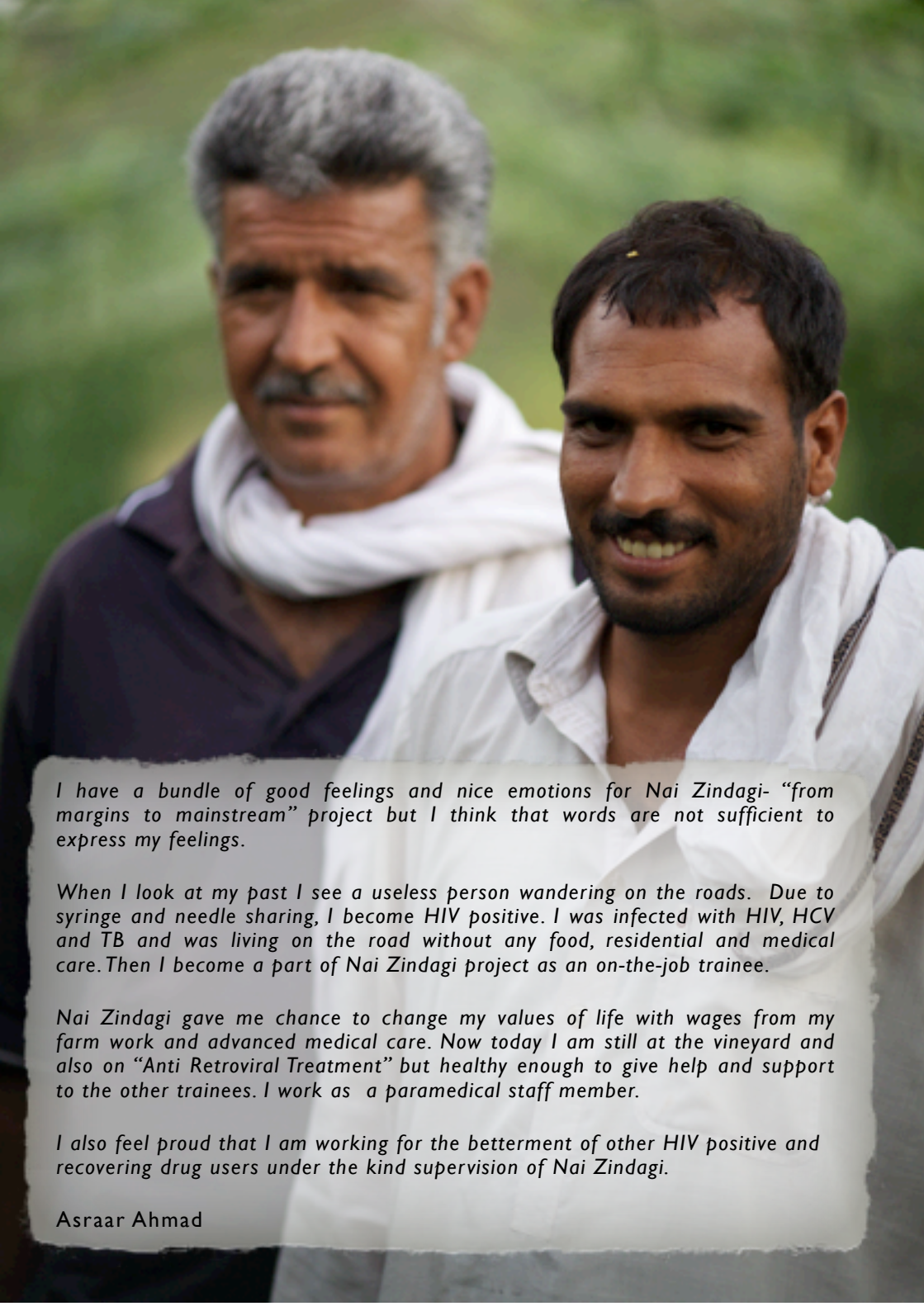
Socio-economic reintegration

One of the most important outcomes that was discovered through exposure to and conversation with people living on the streets was the response generated by the requests for employment. The discovery of this request was a watershed experience for community-based organisations. In many ways, those providing health and social care services had nowhere to place such requests. Most had no business experience, and many were suspicious of the business ethos.



I have a bundle of good feelings and nice emotions for Nai Zindagi- "from margins to mainstream" project but I think that words are not sufficient to express my feelings.

When I look at my past I see a useless person wandering on the roads. Due to syringe and needle sharing, I become HIV positive. I was infected with HIV, HCV and TB and was living on the road without any food, residential and medical care. Then I become a part of Nai Zindagi project as an on-the-job trainee.

Nai Zindagi gave me chance to change my values of life with wages from my farm work and advanced medical care. Now today I am still at the vineyard and also on "Anti Retroviral Treatment" but healthy enough to give help and support to the other trainees. I work as a paramedical staff member.

I also feel proud that I am working for the betterment of other HIV positive and recovering drug users under the kind supervision of Nai Zindagi.

Asraar Ahmad

A challenging request

The request for work also challenged organisations that are committed to the principle of harm reduction. Would responding to requests for detoxification, drug treatment, employment, and leaving behind a life on the streets mean watering down the non-judgemental approach adopted in providing services that concentrate on reducing the harm caused by drug use?

The request challenged existing orthodoxies, and confronted community-based organisations with their own inadequacies and prejudices regarding business development and profit. But these requests could not be ignored. If integrity was to prevail above orthodoxy, then the request expressed from the street had to be acknowledged.

The response

Over a period of ten years, community-based organisations learned and adapted. Small training businesses were introduced that supported and provided employment to a marginalised, unskilled population. The benefits were immediate. Expensive detoxification and treatment programmes were dramatically shortened in duration. Street-based drug users were seen as a valuable human resource, and their identity as employees and contributors to new business ventures established their status. The stability of life that ensued helped encourage adherence to treatment regimes for HIV and TB.

Impediments

The biggest impediment to developing this part of the continuum was muddled thinking. In the beginning, many community-based organisations believed that developing skills-training programmes was the answer. But this eventually exposed a serious fault line. Skills-training programmes cannot introduce the culture of the workplace. There are no deadlines to meet in training programmes. There are no customers demanding quality and value for money for the products or services created. The person remains a trainee, and is not associated with a business, which precludes satisfaction that is achieved of making something that sells, or providing a service that people like enough to come back. The training centre was eventually seen as a facsimile of the real thing.

Friends @ 240

Friends @ 240 is an important example of how a business venture can make a big difference. Marie Courcel, an entrepreneur within the Friends International team, recognised a number of things about the Cambodian market.

In the first instance, she perceived that teaching people to make specific products was not sufficient to guarantee their future. Within an Asian context, successful new products are copied prodigiously. That means the life span of a niche product is short. Within three weeks, the market can be flooded with copied versions.

Marie understood, therefore, that the training business must also inculcate design, creativity and innovation,. Marie recognised that creativity was as important as literacy. Friends @ 240 was set up as a business venture, teaching design and production of urban street wear and accessories with a unique Khmer influence.

The shop is based in Street Number 240, the Bond Street of Phnom Penh - hence the business name. Attached to the shop are over 100 producers - women and men who are poor and whose children are vulnerable particularly to the drug culture. These producers were introduced to design and experimentation alongside production of saleable items. Many of the designs created by producers were adopted and subsequently found a market. This imbued producers with confidence and articulacy.

Marie also appreciated that there could be no compromise on the quality of products produced and sold. Producers manufacture items at home - as a cottage industry. The weekly purchase of products by the Friends @ 240 buyer was a key event. Only those items which passed stringent quality control were purchased. There was no place for excuses or sentimentality. This approach introduced producers to the tough reality of the market place.

In general family income tripled as a result of the business venture. Friends @ 240 is a social business and dovetailed with the continuum of care. The business provided access to health care and advice. Families received health insurance as part of their contract as producers. Their children were introduced to schooling as part of the overall continuum of care developed by Friends International, the host organisation.


SHOP
MADE IN CAMBODIA
WORK
SHOP
MADE IN CAMBODIA
TAILORING
SERVICE
MADE IN CAMBODIA
KIDS +
ADULTS
CLOTHING
MADE IN CAMBODIA
FITTING
ROOM
MADE IN CAMBODIA

Over time, skills-training programmes were also seen as putting too much pressure on the wrong place. Skills-training programmes were seen as easy on trainers, as they are under no obligation to ensure products or services were marketable. Likewise, these programmes did not remove the burden from the trainee, as they still had to find a job upon completion of their training, and their CVs were still empty. They still had to go out and discover if they could earn their keep.

Ongoing funding became the acid test. Where organisations sought to develop skills training programmes (vocational training schemes), these ventures failed when project funding ceased.

A business focus

On the other hand, the move to develop a successful business venture represented a huge challenge to community-based organisations that provide health and social care. Creating a supportive business ethos became essential. Many new competencies needed to be absorbed. Business plans had to be understood and constructed. The marketplace needed to be analysed to identify niche products or services. A capacity inventory of prospective trainees needed to be conducted.

Failures honed the pathway to success

There were perils. In the beginning, many organisations focused on production rather than the marketplace. Consequently, many wound up producing a product that had no market value. In addition, in many situations the cost of manufacturing even marketable products exceeded the potential sales price. In effect, the business venture ended up requiring a financial subsidy from the host organisation, which further depleted vital health and care resources. Once again, when project funding disappeared, these ventures collapsed.

Many organisations drifted towards production of products that did not provide a stimulating environment for trainees. To retain interest, to provide opportunities, training businesses needed to be creatively challenging and labour intensive. People who have survived on the streets are extremely resourceful. Their potential and creative capacity needed to be recognised and trusted. Being part of a venture that was creative and challenging engaged and capitalised on this potential and experience. On the other hand, when ventures where established that did not engage the creative interest of trainees, they also quickly wilted and failed.

Aspiration central to success

Starting a business venture was also discovered to be essentially aspirational. Goal-setting often determined the outcome. The temptation for some organisations was to settle for what was described as an "income-generating project". This term suggested that the venture would not make a profit after costs were taken into account, but that some income would materialise through sales that would contribute to defraying some of the overall costs involved in running "the project". This became an inherently flawed approach. Effectively throwing in the towel before the venture began, it reinforced the "project-focussed" mentality. Some organisations began along this road and eventually moved towards a business focus. Those that retained an "income-generating" focus continued to need additional funding. When this top-up funding disappeared, these "projects" often collapsed.

Business and mainstream

By setting out to develop a business venture, organisations moved towards the mainstream. The measure of success, or the yardstick of accomplishment, became similar to those of any business. Are the goods or services of high enough quality to compete in the marketplace? Are the business planning, cost control, cash flow analyses sufficient to guide the business towards profit and its own market niche? Setting aspirations at this level galvanised the work force and trainees.

Teaching people how to make money

After many years and many successful businesses, community-based organisations began to realise that the main objective was to teach people how to make money. Other specific skills learned during the training period were secondary to this. It therefore became essential that training was provided within a successful and profitable business environment. This provided an example and an object lesson for trainees that built their confidence. Training that was provided in any other environment was like asking the individual to succeed where the organisation itself had failed.

Cross-fertilising for win-win

An interesting by-product witnessed in setting up business ventures was that the newly-acquired business culture enhanced the provision of healthcare. Exchanging staff across sectors, from healthcare to business and vice-versa, energised both. Those in the healthcare sector transferring to business understood how control of costs is essential, and that quality control and customer satisfaction are pre-requisites for success. When they returned to working in healthcare, they became more cost conscious, which led to greater efficiency for the organisation. They also recognised that the satisfaction of those using the service was not something to take for granted.

Those from the business sector who began working in healthcare returned with a greater understanding of the journey that trainees had to make, and were therefore better equipped to provide the necessary support.

The value of social entrepreneurs

The development of successful training businesses across Asia owed much to the social entrepreneurs who provided the necessary vision, nous and leadership. Social entrepreneurs were present in Pakistan, Cambodia and were learning the ropes in India and Nepal. Once businesses were established by these entrepreneurs, they continued to provide opportunities for individuals to gain employable skills and an escape route out of poverty.

Some of the businesses that were established predate Mainline's involvement. Over the past twelve years, successful businesses have been established by Nai Zindagi in Pakistan - high-end furniture design and manufacture; luxury quality leather craft goods; vintage vehicle restoration; vineyards growing table grapes; show-dog breeding and training; vegetable cultivation and sales. Successful businesses initiated by Friends International and Mith Samlanh in Cambodia included highly-recommended and profitable restaurants with illustrated cookery books as spin-offs; urban clothing and accessories design and manufacture. In Nepal and India, farms dedicated to vegetable cultivation and sales were established.

Socio-economic reintegration and life stability

Providing training and employment enabled street-based drug users to achieve life stability, which guaranteed access and adherence to vital treatment programmes, particularly ART and TB. Other elements of the continuum (provision of nutrition, OST, and practical support) dovetailed to help people using drugs gain more control over their previously chaotic lives, take advantage of vital services, and realise their potential.

EXPOSURE

Securing the continuum in an enabling context

The importance of continuity

Significantly, over the last few years, there have been many occasions in Asian countries where vital healthcare services for people using drugs have been interrupted. Too often, this has taken place in a political and social environment where decision-makers and local community leaders are oblivious to what is being lost. These leaders are uninformed about the value of the various integrated services that form the continuum.

Yet the dynamics of the HIV and HCV epidemics neither apologise for nor take into account failures in understanding, knowledge, poor decision-making, and the construction of ill-informed policy. When services are interrupted, terminated, or curtailed, people are left vulnerable. The disease marches on, and continues to claim its victims. When services cease, the prevalence of the disease rises rapidly.

Community-based organisations have had to come to terms with the fact that much of what they have been creating within the continuum had taken place in isolation. As the continuum was being constructed, local leaders were not kept informed, and politicians were not made aware of the importance of what was being achieved. Consequently, when crises occurred or vital services were terminated, politicians and community leaders were uninformed about the drastic consequences of both action and inaction. At that point, the development of the continuum endured major setbacks, shattering the hard-earned trust and confidence of the people and families affected by poverty, drug use and HIV.

Building in partnership and not isolation

From these difficult experiences, community-based organisations are learning that building the continuum of care must include cultivating partnership and understanding among local civic leaders. As public representatives become aware of the value of this integrated approach, they become its advocates and protectors. To achieve this, community-based organisations need to become better at public relations and the dissemination of their work. Publications, stories, publicised events, and inviting public leaders to view and comment on the services being provided will promote this approach.

Although the priority of disease control is paramount, local community leaders do not often recognise this at first. The value of the continuum in reducing petty crime and supporting the reintegration of marginalised individuals is often a good place to start with local political representatives. From that position, the journey into understanding the full contribution of the continuum can be assisted.

In recognising the importance of an enabling political context, Mainline and its partners have come to understand both the common ground and challenges experienced across Asia. Drug consumption and its effects do not stop at national boundaries and frontiers. What takes place in Delhi one year will travel to Lahore within six months. The fast-changing environment of drug use means that practices in Bangkok quickly migrate to Phnom Penh and Kuala Lumpur.

Within this context, Mainline's partners developed a regional movement called Response Beyond Borders, which provided a mechanism and structure for consultation, identifying challenges and priorities, and outlining a response.

EXPOSURE

Response Beyond Borders

Response Beyond Borders (RBB) is a movement initiated in 2008. Essentially RBB derives from a recognition that the HIV epidemic does not stop at national boundaries. This means that an effective response is built upon consultation and collaboration across these boundaries.

In addition, Asian partners recognised that the international forums for addressing the challenges posed by the HIV epidemic worldwide were not able to focus on the unique challenges that Asia faced. A home-grown solution was called for. An Asian-driven analysis of its priorities, as well as an Asian-focussed response to these challenges, was required.

RBB is a forum for consultation and the identification of the challenges that face Asia from the triple nexus of poverty, drug use, and HIV. From the outset, RBB sought to encourage participation from a wide range of stakeholders: politicians and public representatives, government representatives, international donors, relevant UN bodies, civil society, and most importantly representatives from affected populations.

RBB has brought about a dialogue between politicians and affected populations. RBB supported the development of the Asian Network of People who Use Drugs (ANPUD). The Asian Forum of Parliamentarians for Population and Development (AFPPD) was also supported to form a parliamentary standing committee on harm reduction. As a result of consultation, RBB has identified the following priorities facing the Asian region regarding drug use and HIV:

The absence of support for, and focus on, wives and families of men who use drugs;

The absence of relevant support for young people (minors) who use drugs;

The absence of treatment for Hepatitis C;

The ubiquitous presence and dangers of ineffective and compulsory drug detention treatment centres.

RBB provides a platform for a regional response to the epidemic. It ensures that the efforts in building a constructive response are built on the continuum of care, and do not take place in a political vacuum. RBB seeks to take a regional lead to ensure that priorities are identified, that solutions are valued and understood, and that political will and donor support are galvanised in the most effective way.

EXPOSURE

Conclusion

The continuum of care described here to a comprehensive response to drug use, poverty and the threat of HIV and AIDS generates a template through which politicians, donors, community leaders and community based organisations can address the full human and community needs and potential of those affected.

It asks all to think laterally, to become exposed to and familiar with the individuals and communities so burdened. The examples provided by the many community based organisations who have pioneered this initiative need to be studied and widely replicated.

Community based organisations, for their part, should also embrace the challenge of reaching out to others and situate their achievements in wider pubic debate by engaging community, local and national leaders in understanding the breath, scope and vision of what they have put in place.

Only then will the potential of marginalised individuals and communities be harnessed for their own development and inclusion, and their contribution be facilitated and recognised for the benefit of society as a whole.

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